

DEPARTMENT OF HUMAN SERVICES
TRANSFER FORM for MAINECARE MEMBER ONLY

IF NOT A MAINECARE MEMBER, DO NOT COMPLETE THIS FORM.

Consumer Name: _____

MaineCare Number:

Facility Name: _____

Facility Telephone # _____ Facility Fax # _____

Facility Contact Person _____

NEW ADMIT TO YOUR FACILITY (send only to Goold Fax# 1-800-368-0965) Date _____

HOSPICE (send only to BMS-CR Fax# 287-6533)

Specify NF Home Date _____

TRANSFERRED TO (send only to BMS-CR Fax# 287-6533)

Hospital: Bedhold Request (required if hospital stay > 24 hours - Section 67.05-11)

Hospital name _____ Date _____

Your nursing facility from hospital (Section 67.05-11) Date _____

SNF Medicare YES NO

Medicare Benefits Reinstated by NF Date _____

DISCHARGED TO (send only to BMS-CR Fax# 287-6533) (Sec 67.05-9)

Home Address _____ Date _____

Residential Care (name) _____ Date _____

Other Nursing Facility (name) _____ Date _____

HHA (name) _____ Date _____

Death Date _____

End Hospice Status Date _____

Deceased at Hospital Date _____

Person completing this form: _____